HARFORD COUNTY HEALTH DEPARTMENT

Influenza Immunization Consent Form
Please Print Information

I HAVE READ OR HAVE HAD EXPLAINED TO ME THE INFORMATION ON THIS FORM ABOUT INFLUENZA AND INFLUENZA VACCINE. I HAVE HAD A CHANCE TO ASK QUESTIONS WHICH WERE ANSWERED TO MY SATISFACTION. I BELIEVE I UNDERSTAND THE BENEFITS AND RISKS OF INFLUENZA VACCINE AND REQUEST THAT THE VACCINE BE GIVEN TO ME OR TO THE PERSON NAMED BELOW FOR WHOM I AM AUTHORIZED TO MAKE THIS REQUEST.

NAME:_____
Last First MI

GENDER: M F BIRTHDATE: _____ AGE:_____

ADDRESS:_____

CITY:_____STATE:_____ZIP:_____

I acknowledge that I have received today or have received in the past, a copy of the Notice of Privacy Practices with an effective date of April 14, 2003.

*SIGNATURE*_____*DATE*_____

1. **Are you allergic to eggs? Yes No**
2. **Have you ever had a serious reaction to a vaccine in the past? Yes No**
3. **Have you developed Guillain-Barre Syndrome within six weeks of getting an influenza vaccine previously? Yes No**
4. **Are you sick with a fever? Yes No**
5. **Type of primary insurance (Please circle): Private Medical Assistance Medicare None**

   If Medicare, please provide your Medicare # for billing purposes:

Staff Initial_____

For Clinic Use Only
Date of Clinic:_____
Clinic Site: Ripken stadium, Richlin Ballroom, Mtn. Christian, Evangel, Level Human Resources, Middle School (Edgewood,Aberdeen,N.Harford,Southampton)

Manufacturer and Lot#:_____or_Apply label:
Indicate administration site: LA RA Nasal (FluMist®)
Pediatric dose:_____ L Thigh R Thigh
Nurse's signature or initials if signature is on file:_____

9/06